Combat Psychiatry

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Outline - Discuss:

- Symptoms of Combat Stress Reactions (CSR)
- Risk Factors for CSR
- Management of CSR (NOT TREATMENT)
- Prevention of CSR
- Combat Stress Control Unit

How Does One Overcome the Fear of Combat?

- “Delusion” of Omnipotence
- Strong faith in leaders
- Conviction that an individual’s peers will protect him/her

Combat Stress Reaction (CSR)

- Also called Combat Fatigue
- A normal condition that occurs in normal combatants under abnormal circumstances
- A person's psychological defenses are overwhelmed and the person is temporarily unable to fight or function
- Combat Stress Reaction is (intentionally) NOT a psychiatric diagnosis

Combat Psychiatry's Goal

- To prepare as many personnel as possible for combat (and thus to prevent Combat Stress Reactions)
- To restore personnel with Combat Stress Reactions to full duty
- To recognize and treat CSR - to prevent development of psychiatric illness and disability
- Some dispute that less morbidity with RTD

Normal Physiological Reactions to Combat

- muscle tension/tremor/cramping/shaking
- diaphoresis (sweating)
- tachycardia (increased pulse rate)
- increased blood pressure
- tachypnea (increased breathing rate)/hyperventilation
- diarrhea and increased urinary frequency

Normal Psychological Reactions to Combat

- fear/panic attacks
- apathy
- depression
- concentration
- crying
- irritability/anger
- insomnia
- fatigue/exhaustion
- helplessness
- frustration
- poor

Behavioral Symptoms of Chronic Combat Exposure

- hypervigilance
- exaggerated startle response (hyperarousal)
- alcohol or drug abuse
- “sick” humor
- excessive griping
- withdrawal from the group
- psychomotor retardation

Severe Symptoms of CSR

- overwhelming fear/inconsolable/hysterical
- fleeing combat/refusal to fight/fear of flying
- self mutilation/suicide attempt
- incoherent speech
- severe cognitive defecits (e.g., thought blocking, memory defecits, disorientation)
- psychosis

Severe Symptoms of CSR (cont.)

- catatonia (immobility; excessive motor activity)
- mania
- somatoform or conversion symptoms (loss of motor or sensory function WITHOUT a neurological or medical cause)
- inappropriate alcohol or drug use
- dissociation (amnesia, depersonalization, feeling “dazed”)

Classification of CSR

- Often classified as mild, moderate, or severe
- Formal DSM-IV diagnoses avoided, unless the member will be transferred “to the rear” for lengthy and definitive psychiatric care (e.g., Brief Psychotic Disorder or Major Depressive Disorder)
- This avoids giving the patient the impression that he has a medical or psychiatric illness

How to Differentiate CSR from Normal Combat Anxiety

- symptoms interfere with functioning
- symptoms exceed those of peers
- symptoms persist long after exposure to the trauma ends

Organic Causes of Combat Stress Symptoms

- **Be alert for these potentially fatal conditions!**
- head injury (intracranial bleed)
- spinal cord injury
- infectious disease (including biological war)
- dehydration
- severe sleep deprivation

Other Organic Causes ...

- illicit drug toxicity or withdrawal (e.g., stimulants, benzodiazepines, hallucinogens)
- prescribed drug toxicity or withdrawal (e.g., stimulants)
- alcohol intoxication/withdrawal
- chemical or nuclear warfare agents
- chem. warfare antidotes (ex. atropine - anticholinergic psychosis)

Risk Factors for Combat Stress

- Environmental/Situational
- Operational/Organizational
- Individual
- Phase of Deployment

Environmental/Situational Risk Factors

- adverse weather, terrain, noise
- greater combat intensity and duration
- viewing wounded (esp. violent, grotesque)
- suffering a wound
- participating in atrocities
- surprise attack (e.g., ambush, terrorism)
- nuclear, biological, or chemical attack (and threat - leads to anticipatory anxiety)
- wearing MOPP gear

(Cont.)

- inadequate food
- poor sleep; fatigue; inadequate leisure time
- poor field living conditions and sanitation
- infectious disease (presence and threat)
- well equipped and trained enemy with high morale and motivation
- lack of knowledge about mission effectiveness

General Rule:

- **Increased risk for combat stress with**:
  - greater number of risk factors
  - increased severity of risk factors
  - longer exposure to risk factors

Operational/Organizational Risk Factors

- poor leadership
- poor unit cohesion/morale (small unit)
- uncertainty about mission or role
- lack of home support for mission
- lack of/inaccurate information
- poor training (for combat and field living)

(Cont.)

- outdated equipment (lack of confidence in the equipment capability) e.g. aircraft
- unpredictable deployment schedule (due to “rightsizing” and dynamic, unstable international situation)

(Cont.)

- deploying units with recently assigned personnel that have not trained together (reservists)
- support troops (non-combat front line):
  - often less well trained to cope with combat
  - helpless feeling at fixed base
  - exposure to carnage and suffering (of combatants and civilians) e.g. body handlers
  - harassed by locals (and cannot retaliate)
  - surprise attack (missile; aircraft)

Individual Risk Factors

- age (very young or older)
- single/divorced
- minority or female facing discrimination
- lower rank (USNS Comfort study)
- lack of training and experience
- lack of commitment to the cause
- recently assigned to the unit
- worry about family at home (reservists)
- financial stress (e.g. reservists lose job)

(Cont.)

- Poor physical fitness (gauge: combat exercise endurance; NOT PRT score)
- medical illness
- preexisting psychiatric disorders (and risk for illness):

  - Axis I (e.g. PTSD from prior combat)

  - Axis II personality disorder or maladaptive

    personality traits

Phase of Deployment Affects Stress

- Predeployment phase:
  - boredom, anticipatory anxiety, substance abuse
- Initial phase:
  - high operations tempo, new environment, exhaustion, marked anxiety
- Middle phase:
  - family concerns

(Cont.)

- Final phase:
  - stressful if delay in leaving
- Homecoming:
  - grief for loss of unit camaraderie
  - family readjustment

Risk Factors for Aviators (literature sparse)

- threat of injury from antiaircraft fire
- injury or death of friends
- participation in destructive mission
- sustained operations (SUSOPS) - delays treatment of CSR
- wearing Aircrew Chemical Defense Ensemble

CSR Symptoms in Aircrew

- careless flying
- cognitive impairment
- ingrained physical skills preserved, despite severe fatigue

Note: aviators less prone to CSR than non-aviators

Medical Units at Risk for Combat Stress

- may not train together as a unit (if mobilized for the specific conflict)
- sometimes uncertain about their role
- lack of support from the combat unit that the medical unit supports (as do not train together; perceived as draining supplies from the combat unit)
- less risk for CSR if previously handled corpses, or cared for dying patients

Special Challenges for Mental Health Units

- not perceived as important by the line and medical units - as deal with intangible, nonphysical injury - *and return stressed combatants to duty!*
- may not receive adequate support from the medical unit to which the mental health unit is attached

How Common are Combat Stress Reactions?

- estimate **1** combat stress casualty for every **2** to **5** wounded
- more combat stress casualties (relative to wounded) in NBC environment
- Desert Storm: anticipating longer war, the Army predicted that there would be 1400 combat stress cases per week (with 1190 returned to duty)

When do Combat Stress Casualties Occur?

- incidence high in the first week of combat (40% in one article)
- incidence declines to a stable rate over the next 3 weeks
- anticipate an increase again after one month (prolonged combat)

Treatment of Combat Stress Reactions

- **BICEPS** mnemonic
- Brevity: brief treatment with goal of return to duty within 3 days (or medevac to rear)
- Immediacy:

  - treat as soon as condition recognized

  - begin with aid by buddies, chaplain, corpsman, etc.

BICEPS Treatment (cont.)

- Centrality:
  - treat CSR victims in one area (not part of medical unit) to avoid labeling as “ill”
  - may occur near combat unit, battalion aid station, or field hospital (safety is key)
- Expectancy: instill message that person is having acceptable and temporary reaction to stress - and will soon return to duty

BICEPS Treatment (cont.)

- Proximity: treat near member's unit (bond
- Simplicity: - avoid psychotherapy
  - avoid drugs (Ambien/benzo. ok for sleep)
  - food, sleep, shower, clean uniform
  - routine - exercise, work detail (in rate/ MOS), occupational therapy, games
  - military milieu ensures discipline

Simplicity (cont.)

- **Critical Incident Stress Debrief (CISD)**
  - group session(s) - to discuss member's role, behavior, thoughts and feelings in combat
  - teaches normality and universality of combat stress behavior, coping skills, and stress management

CISD (cont.)

- Some dispute that CISD effective, especially if performed before the traumatic event has ended
- CISD may increase morbidity
- Participants generally deem it useful

Prognosis for Treated Combat Stress Reactions

- One article predicts that **30 %** of the casualties will return to duty within 24 hours - and **90 %** return to duty within 72 hours
- Another article noted a recurrence rate of 7 % for treated members - and noted that **5 %** will require medevac out of theater
- A few members will need to be assigned to support duties, instead of combat duties

What DSM-IV Diagnoses Apply to CSR Patients?

- Combatants who suffer CSR - and ultimately return to duty may have:
- V- Codes
- Adjustment Disorders (+/- suicidal ideation)
- Somatoform Disorders (e.g. Conversion Disorder)
- Malingering

Who Needs to be Medevaced?

- Major Depressive Disorder
- Bipolar Disorder
- Psychotic Disorders
- Anxiety Disorders (Panic Disorder, PTSD)
- Patients with persistent suicidal ideation
- Unresolved/recurrent Conversion Disorder
- Dissociative Disorders (amnesia)
- Commanders with any CSR presentation

Techniques to Prevent Combat Stress

- Do not deploy members with psychiatric diagnoses
- physical fitness
- the best possible food, shelter, sanitation
- adequate sleep (minimum 4 hours; 30 minute naps) - and leisure time

note: aviators need 8 hours of sleep with "no fly" days

Prevention (cont.)

- cycle units in and out of combat (rest days)
- realistic, frequent training (field living, combat, NBC)
- teach small unit leadership
- maintain “busy” training schedule

Prevention (cont.)

- provide modern equipment
- ensure families are cared for
- rotate units into and out of the theater as a unit (maintain unit integrity)
- leaders live with and visit troops often
- disseminate accurate information often
- maintain discipline

Prevention (cont.)

- promote morale and unit cohesion (awards ceremonies, distinctive insignia)
- team building (routine, sports, combat exercise)
- “buddy system” (assign veterans to care for new troops)
- teach about CSR - symptoms, prevention, “buddy aid”

(Cont.)

- teach stress management (ex., sleep hygiene)
- teach about NBC and disease threat - and prevention
- memorial services and mourning rituals

Prevention (cont.)

- **Critical Incident Stress Debrief** (longer process/small groups/interactive) vs. **Defusing (**brief session/larger group/noninteractive) - after:
  - training mishap (injury or death)
  - enemy or friendly fire casualties
  - accidental injury (detonation of mine)
  - exposure to dead, wounded, civilian suffering

Combat Stress Control (CSC)

- In future conflicts (combat, peacekeeping missions), military mental health assets will perform a variety of functions
- Combat Stress Control (CSC) Units - will be created to train with and deploy with operational units (ship and ground)

Combat Stress Control (cont.)

- The basic CSC element will likely be a highly mobile **3** person team that will travel with, (and circuit-ride among), forward “tip-of-the-spear” combat units
- The future Marine may have a personal computer that can monitor sleep quantity, stress levels, etc.

Combat Stress Control Functions

- Consultation to unit leaders about mental health concerns (assess unit stress, morale)
- Teaching (before deployment/combat):
  - stress management
  - Combat Stress Reaction prevention
  - Critical Incident Stress Debrief/Defusing
  - recognition of CSR
  - “buddy aid” for CSR victims

CSC Functions (cont.)

- Triage of psychiatric patients
- Brief stress debriefs/CISD - for wounded, medical personnel, litter bearers, morgue personnel, combatants, etc. (**may** prevent Acute Stress Disorder, PTSD, Depression)
- Restoration - Combat Stress Reaction "treatment" to restore members to full duty within 72 hours (and return to own units) ex. - at battalion aid station

CSC Functions (cont.)

- Reconditioning - more intensive treatment in rear field hospital(1 to 2 weeks) to avoid medevac out of theater
- Demobilization and pre-homecoming briefs:
  - ease the cease-fire “letdown”
  - help prevent careless behavior (ex. handling unexploded ordnance)
  - prepare for home/reunite with loved ones

Special Challenges for Combat Stress Control Units

- Locate fast moving, mechanized combat units that need CISD
- Return combatants (recovered from CSR) to individual units (up to 72 hours later!)
- Current USMC doctrine: does not include return to unit after medevac to amphibs

“Peacekeeping”/Humanitarian Missions

- Significant incidence of Combat Stress Reactions, PTSD, and other psych. illness
- Factors:
  - changing rules of engagement
  - unclear goals/success hard to measure
  - hostile civilians
  - exposure to refugee poverty, atrocities
  - miserable living conditions for military

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